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From Osler to the *cone technique*

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The Canadian-born physician William Osler (1849-1919) was a renowned diagnostician and clinician. He was one of the pillars upon which the Johns Hopkins Hospital was constructed in 1888, where he later became professor of medicine at the medical school. Osler believed that all medical students should be taught at the bedside instead of having their heads permanently buried in books, and that the patient should be seen as both the starting point and the conclusion of the clinical procedure.

Osler was also famous for his witticisms and philosophical maxims. Many of his phrases on patient management have become almost proverbial, and are still considered forward-looking in today's sterilized world of hospital care. My personal favorite is, *'it is much more important to know what sort of patient has a disease than what sort of disease a patient has'.*

This patient-centered approach differs radically from the more controllable doctor-centered method that still tends to be practiced, where the so-called *doctor-god* interrupts the patient, assuming that he knows exactly what the patient's problem is, puts words into the patient's mouth, and totally runs the show. Indeed, up to not such a long time ago it was doctors that traditionally took the dominant role during consultation. Furthermore, patients considered doctors as god-like beings, thus making their professional expertise unquestionable. Patients did not expect, nor were they expected, to actively take part in the history-taking process, as their health was totally in the hands of their physician. Diseases were studied from textbooks or in lecture theaters, and patients were looked upon as victims of these diseases. However, the disease and the patient were very often considered separate entities, and during the consultation history taking was limited to a few *closed questions* regarding the functioning of an organ or a system in order to reach an accurate diagnosis. Using this method, the impact of the disease on the patient's life was barely considered.

So, it was very much a problem of a disease's impact on an organ, rather than the devastation of a person's existence caused by an illness.

Following the initial creation of rapport, and after having made certain that the patient is feeling comfortable and relaxed, a doctor has to find out what the *presenting complaint* is. The patient should always be allowed to describe his symptoms and sensations using his own words, and the logical way to do so is by using the so-called *cone questioning technique*. There are numerous types of question you might use to get the answer you are looking for, from closed questions that require simple yes/no answers to open questions, also known as *what/who/when/where/which/how* ques-

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Table 1 - *Differences between Doctor-centered and Patient-centered approach.*

Doctor-centered approach
- Tightly controlled
- Doctor has dominant role
- Patient participation is limited or not expected
- Patient's health is in doctor's hands
- Doctors ask leading and assumptive questions
- Impact of disease on patient's life not considered
Patient-centered approach
- Patient is the expert of his disease
- Patient is a source of information
- Holistic approach used by doctor
- Physical, social, economic factors considered
- Doctors show empathy
- Patients more ready to comply
- Doctors respond to patient cues

tions, that need more elaborate replies. Doctors should try to avoid asking *why* questions, as the patient might feel judged and therefore uncomfortable. Multiple questions (e.g. Is the pain always in the same place and how would you describe it?), leading questions (e.g. Does the pain start in the morning?), and tag questions (e.g. The pain is worse after meals, isn't it?) should be avoided.

The cone technique begins with open questions and moves gradually on to closed questions. This ensures an initial picture of the presenting complaint from the patient's perspective.

The doctor then duly moves on to closed questions, which are used to confirm specifics and understand the cause of symptoms in a more technical context. Indeed, as the consultation progresses closed questions can be used successfully to focus specific areas that maybe do not emerge from the patient's *story* during the initial open-question session.

In conclusion, we can see how the *god-like approach* differs totally from the more holistic *Osler-style approach (Table 1)*.

We might therefore say, *'the good physician treats the disease, the great physician treats the patient who has the disease'.* (Sir William Osler 1849-1919).

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